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Explaining Medicare Part D's "Split Deductible" Design

Dispelling the Myths of the "Doughnut Hole"

Executive Summary

- America's seniors finally have a prescription drug insurance benefit under Medicare because Congress and President Bush acted to create it.

- Just nine months into its first year, the Medicare Part D program is exceeding all expectations. Seniors report spending less than half of what they used to before Part D. And enrolled seniors are overwhelmingly satisfied with the program.

- However, opponents of Medicare reform continue to criticize the design of the standard Part D plan, likening it to a "doughnut" with a gaping "hole," and telling seniors that millions will "fall into" a "hole from which few will escape."

- But the design is actually very thoughtful and has the best interests of seniors in mind. It combines two key benefits – a basic savings benefit as well as a catastrophic insurance benefit. There are out-of-pocket amounts that must be paid before accessing each level of benefits – <u>like an insurance deductible "split" in two portions</u>. (While this explanation may not use the technically correct insurance terms, this paper aims to make the "doughnut hole" design of the standard plan more understandable to more people.) In addition, the so-called "hole's" effects will be relatively limited this year, and this issue is likely to be far less controversial next year and going forward.

- The standard "split deductible" design guides most of the Medicare drug plans, but there are plans in every state without "holes." Any senior currently in Part D could have enrolled in such a plan for this year and will have the option to switch into one this November. <u>Some will prefer a plan with a "hole" and others will not.</u>

- The key to the Medicare drug benefit's success is its innovative use of market forces and private competition to provide a range of choices to suit seniors' differing needs.

- This is the very first year of a landmark program. While it has already proven successful, it can only improve from here. Better options, tools, and information, as well as increased awareness, will help dispel the myths and maximize the assistance America's seniors deserve.

Introduction

Medicare has long provided senior citizens with insurance for hospital and physician services, but prescription drugs only became covered as of this year by the Medicare Part D program. Congress created this new benefit in the Medicare Modernization Act (MMA) of 2003. Congress's innovative market-driven approach envisioned that competitive private entities known as Part D plans ("plans") would deliver the program's generous benefits to seniors. The program began on January 1, 2006 and nine months later, the results have exceeded all expectations:

- Because of Medicare Part D, about *90 percent of Medicare beneficiaries have coverage*. About 23 million were enrolled in Medicare Part D by the 2006 deadline of May 15.[1]
- Enrolled seniors are overwhelmingly satisfied with the program, with more than 80 percent reporting satisfaction in recent surveys).[2]
- On average, seniors report that they are paying *less than half of what they paid monthly for medicine before Part D began*.[3]
- About *10 million low-income seniors* are receiving their needed medications with very little cost-burdens.[4]
- Robust competitive bidding between the Part D plans has helped bring the average monthly premium down to $24 – *about 40 percent lower than initial estimates.*[5]
- All *taxpaying Americans* will save money as both the federal and state costs of the program have dropped 20 percent below initial projections, due largely to the strong private competition to deliver high benefits at low costs – just as the MMA envisioned.[6]

Nevertheless, an important facet of the program has been distorted by its opponents and subsequently has been widely misunderstood. That aspect is the basic design of the standard Part D plan. Opponents of the program criticize the design as a "doughnut" with a gaping "hole" and insist that it is both very unusual and very harmful. But what exactly is the infamous "doughnut hole" and why does it exist?

This paper lays out the sound reasoning behind the design of the standard Medicare Part D plan and also discusses why the so-called "doughnut hole" will have a very limited impact on seniors. It explains the design in generally understandable and familiar terms and does not aim to be technical or definitive. Many technical works have already been published on Part D and this paper refers to some of them. Instead, it seeks to help Americans understand that contrary to

[1] Centers for Medicare and Medicaid Services (CMS) "Part D Enrollment Data," June 2006. http://www.cms.hhs.gov/PrescriptionDrugCovGenIn/02_EnrollmentData.asp.

[2] Kaiser Family Foundation poll, June 2006 (showed 81 percent satisfaction); Healthcare Leadership Council, August 2006 poll (showed 82 percent satisfaction); Medicare Rx Access Network, September 2006 poll (showed 82 percent satisfaction).

[3] Public Opinions Strategy, August 2006 poll.

[4] PriceWaterhouseCoopers, "Significance of the Coverage Gap Under Medicare Part D," June, 2006.

[5] Department of Health and Human Services (HHS), "Secretary's Progress Report IV on the Medicare Prescription Drug Benefit" June 2006: http://hhs.gov/medicare4.pdf.

[6] HHS, "Secretary's Progress Report IV on the Medicare Prescription Drug Benefit," June, 2006.

opponents' hypocritical attacks, the "doughnut hole" design is actually thoughtful and fair, and will be far less controversial in the future.

How the Medicare Part D Program Works

The successes of the Medicare prescription drug program thus far are due to its reasoned reliance on market forces. Congress directed Medicare to use competitive private plans to deliver the program's benefits to seniors, correctly predicting that the competition would yield low costs and a range of generous and innovative benefit packages. CMS approved many different plans in every state so that seniors could find the best options for their individual (health, financial) situations.

Most of the benefit packages available are based loosely on the **standard plan** Congress designed in the MMA as a basic blueprint for the private plans to use as a guide. All plans must be at least as actuarially generous as the standard plan, but only about 10 percent of Part D enrollees are in plans that match the blueprint exactly.[7] Nevertheless, the standard plan is what is most commonly used as a basic reference for how Part D works.

The Standard Plan: The Benefits

The standard plan was designed with **two** important benefits in mind.

1. **A basic savings benefit** that provides significant savings for the bulk of seniors' **ordinary** medication needs – including extremely generous coverage for low-income seniors.

2. **A catastrophic insurance benefit** to protect those seniors with **extraordinary** pharmaceutical needs from catastrophic drug costs.

Congress' primary goal in designing Part D was drug insurance for those seniors with the most need – "specifically, beneficiaries with low incomes or high drug costs."[8] While most seniors do not have thousands of dollars of drug expenses each year, catastrophic insurance is critical for those who do, as well as for those who may become unexpectedly ill – which is increasingly likely with age. But Congress also knew it had a responsibility to help the millions of other seniors who had no relief from the rising costs of their ordinary medication needs. Thus, Part D combined both benefits: basic savings **and** catastrophic insurance.

The Standard Plan: The "Split Deductible"

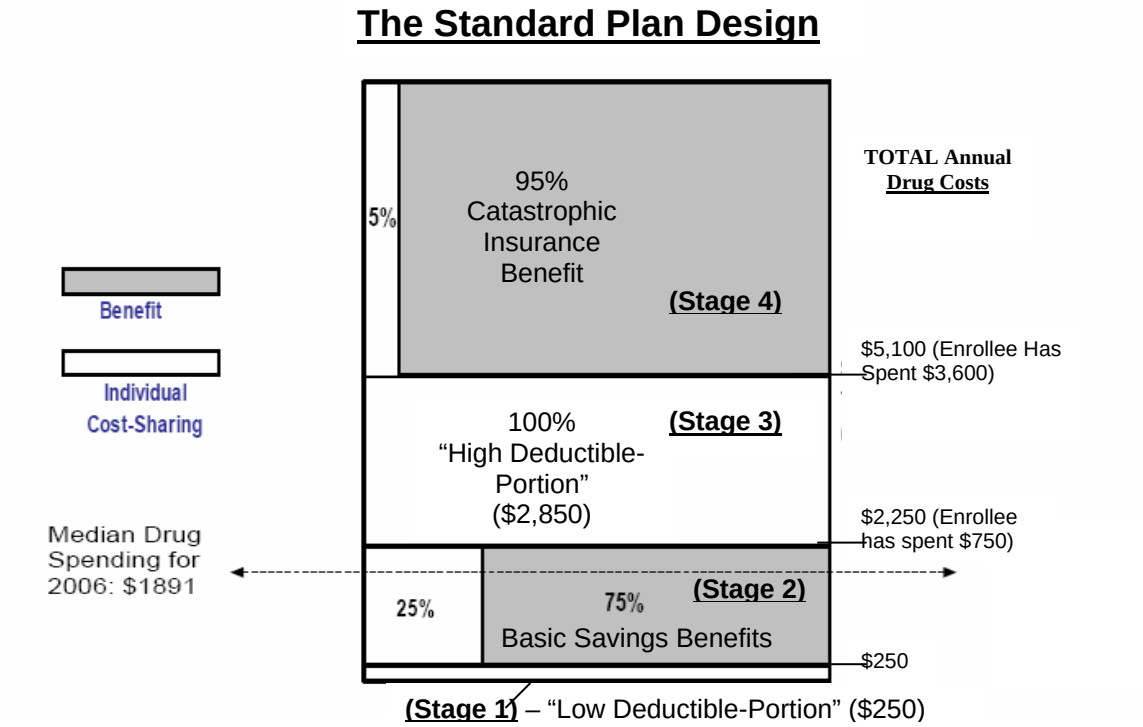
Like any expensive insurance program with catastrophic coverage – such as automobile collision insurance, or homeowner's insurance, which almost all Americans understand and purchase in their lifetimes – there is cost-sharing involved in Part D that comes in the form of

[7] CMS FactSheet, "Strong Competition and Beneficiary Choices Result In Drug Coverage With Lower Costs Than Predicted Last Year," August, 2006.

[8] Senate Republican Policy Committee "Despite Critics' Predictions, Early Milestones Point to Success for Medicare's Prescription-Drug Benefit, Oct. 19, 2005. Available at: http://rpc.senate.gov/_files/Oct1905PartDJS.pdf.

premiums paid monthly, and a deductible that must be paid out-of-pocket before the catastrophic benefits are provided.

The premiums under standard plans are low – often less than $20 per month. The deductible is large, but it is not fully assessed up front like in most other types of insurance policies. **Instead, the deductible is** – in essence – **split into an initial, "low deductible-portion"** (Stage 1 below) and a **catastrophic "high deductible-portion"** (Stage 3 below).



Source: US House Ways & Means Committee

The "split deductible": if all of the deductible were in Stage 1, that would not have helped the majority of seniors with ordinary drug costs of under $2,250 per year. It would have been a barrier to receiving the basic savings in Stage 2, which help millions of seniors afford their ordinary levels of medication expenses.

The standard plan calls for an enrolled senior to pay the low, initial (Stage 1) portion of the "split deductible" before receiving the basic savings benefits (Stage 2). The higher, catastrophic (Stage 3) deductible is the **so-called "doughnut hole."** It is the glue which holds the two benefits together and the split design is what allows basic savings to be accessible to all seniors.

Here is how the numbers work out in 2006 (it will change slightly[9] in 2007):

- **Stage 1 ("Low deductible-portion"):**
  The enrolled senior (enrollee) pays 100% out-of-pocket for his first $250 of total annual drug costs. (Enrollee pays up to $250).

- **Stage 2 (Basic savings benefit):**
  The enrollee pays only 25% of total annual drug costs between $250 and $2,250. (Enrollee pays up to $500, receives up to $1,500 of benefits).

Less than 15 percent of enrollees will have to pay more than this in 2006.[10]

- **Stage 3 ("High deductible-portion"):**
  The enrollee pays 100% out-of-pocket for total annual drug costs between $2,250 and $5,100. (Enrollee pays up to $2,850).

- **Stage 4 (Catastrophic insurance benefit):**
  The enrollee pays only 5% of total annual drug costs above $5,100.[11]

Two Notes:

1. While only a small percentage of all Part D plans copy the standard plan design exactly, most have a similar structure; the cost-sharing percentages and amounts may differ significantly in those plans (next section).

2. The cost-sharing is based on an individual plan's drug prices – prices which each plan negotiates with drug manufacturers on behalf of all its members. At all times, an enrollee benefits from these significantly discounted prices.

Non-Standard Plans: Many Have No "Holes"

While all plans have to meet strict standards for drugs covered and pharmacies included, the flexibility in plan design led to greater consumer choice and also encouraged greater competition between plans which benefited seniors with better offerings for lower premiums. About 90 percent of enrolled seniors are in non-standard plans. Many are actuarially equivalent to the standard plan but have different levels of cost-sharing based on whether a drug is generic or brand name. Some are more generous.

[9] By law, the standard plan's deductible amount and co-payment percentages will be adjusted slightly each year.

[10] PriceWaterhouseCoopers "Significance of the Coverage Gap Under Medicare Part D" June, 2006.

[11] For the remaining 95 percent, Medicare pays 80 percent and the plan pays 15 percent.

[12] Kaiser Family Foundation, "Percent of Medicare Prescription Drug Plans (PDPs) Offering Coverage in the Benefit Gap, 2006."

According to CMS, over 20 percent of all plans effectively have no high deductible-portion (Stage 3**)**. And there are several such plans available in every state.[12]

All seniors have the option of picking a plan without a "doughnut hole."

Some features of these plans:

- They commonly have no low deductible-portion (Stage 1) either, and hence offer immediate ("first-dollar") coverage.
- They generally charge about $20-$40 more than the average monthly premium of $24.
- Instead of paying 100 percent of costs in Stage 3, an enrollee either pays flat copayments or percentages of drug costs, depending on the plan and the types of drugs needed.
- In these plans, enrollees' total monthly expenses are about the same every month. This is not necessarily true in a standard plan because of the split deductible.

Such plans might be very helpful for someone with, say, $5,000 of drug costs per year. But someone with $10,000 of drug costs may prefer a standard plan under which he would pay the high deductible-portion (Stage 3), but then receive generous catastrophic coverage for the remainder of the year.

On the next page is an example of three separate offerings in the state of Arizona. The first is a low-priced ($6 monthly) standard plan with a split deductible; the second is a slightly more expensive ($12 monthly) non-standard plan without a low deductible-portion (Stage 1), but with the standard high deductible-portion (Stage 3); the third is a still pricier ($54 monthly) non-standard plan with neither a low nor high "deductible-portion."

Some Part D plans have coverage for generic drugs but not for brand drugs. But almost everywhere, there is at least one plan offering coverage of brand drugs that has neither a low deductible-portion (Stage 1) nor high deductible-portion (Stage 3).

Under Part D, different seniors have many good options to choose from. And if they are unsatisfied or their situations change, they can always switch plans every fall during the annual "open enrollment season" from November 15 to December 31.

The Minimal Effects of the So-Called "Doughnut Hole"

Opponents of Part D have been trying to scare seniors with horror stories warning that "7 million seniors [will] fall into a doughnut hole from which few will escape."[13] But the "hole" is nothing but the high deductible-portion (Stage 3). And it only significantly affects a very small proportion of enrollees.

[13] Institute for America's Future, "Falling Into the Doughnut Hole: How Congress and the Drug Industry Created a Trap for American Seniors and People With Disabilities," June, 2006 (relies on 2004 projections done by the Kaiser Family Foundation).

An Actual Example of Three Medicare Drug Plans Offered In Arizona

Humana PDP Standard = $6.14/month

Rx Costs	Stage 1 $0-$250	Stage 2 $251-$2,250	Stage 3 Over $2,250	Stage 4 Over $5,100
Rx Type	You Pay	You Pay	You Pay	You Pay *
Generic	100%	25%	100%	5%
Preferred Brand	100%	25%	100%	5%
Non-preferred Brand	100%	25%	100%	5%
Specialty	100%	25%	100%	5%

Humana PDP Enhanced = $11.58/month

Rx Costs	Stage 1 $0-$250	Stage 2 $251-$2,250	Stage 3 Over $2,250	Stage 4 Over $5,100
Rx Type	You Pay	You Pay	You Pay	You Pay *
Generic	$0	$7	100%	5%
Preferred Brand	$30	$30	100%	5%
Non-preferred Brand	$60	$60	100%	5%
Specialty	25%	25%	100%	5%

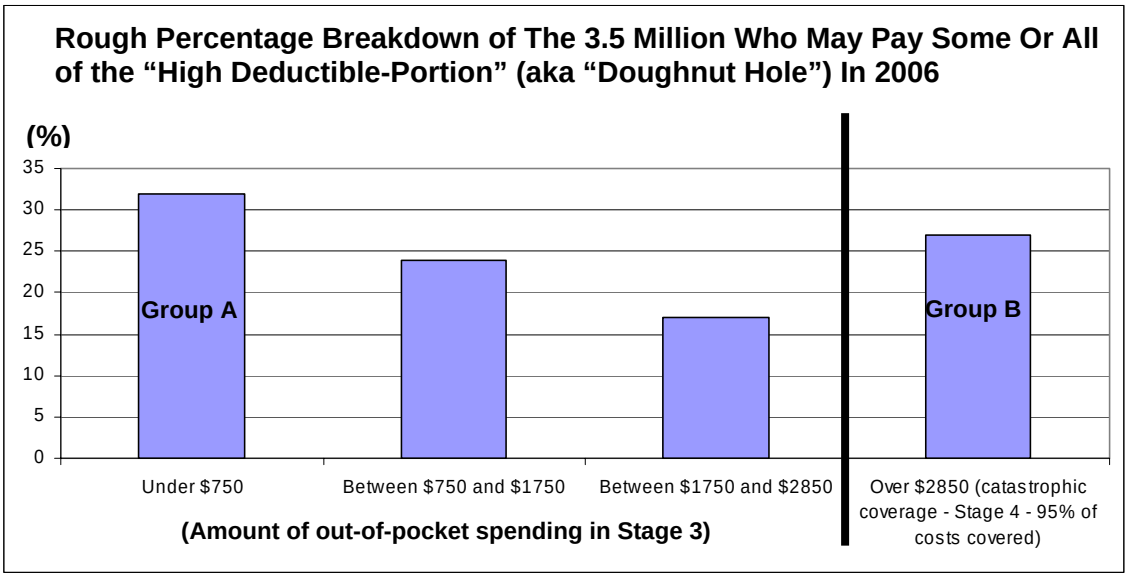
Humana PDP Complete = $53.54/month

Rx Costs	Stage 1 $0-$250	Stage 2 $251-$2,250	Stage 3 Over $2,250	Stage 4 Over $5,100
Rx Type	You Pay	You Pay	You Pay	You Pay *
Generic	$0	$7	$7	5%
Preferred Brand	$30	$30	$30	5%
Non-preferred Brand	$60	$60	$60	5%
Specialty	25%	25%	25%	5%

Source: www.humana-medicare.com

- A recent analysis of CMS' Part D enrollment data[14] developed the following statistics:
  - Nearly 23 million are enrolled in Part D (most of the rest have private/retiree drug coverage).
  - About 10 million of the enrollees receive extremely generous low-income subsidies of different levels – the vast majority pay no premiums **or deductibles** (i.e. no "holes"), and minimal copayments ($0 to $5).
  - About 2.5 million enrollees are in the non-standard plans that have no high deductible-portion (no "hole").
  - About 7 million of the other enrollees simply do not have pharmaceutical needs high enough (over $2,250 a year) to have to pay any part of the high deductible-portion (Stage 3).

This leaves approximately 3.5 million enrollees this year (about 15 percent of all Part D enrollees) who may have to pay some or all of the high deductible-portion (Stage 3) – only about half of what the critics allege. They base their skewed claims on old projections from 2004, long before Part D even began and before either the number and types of plans offered **or** the enrollment patterns of seniors in Part D were known.



Source: PriceWaterhouseCoopers "Significance of the Coverage Gap Under Medicare Part D" June, 2006

By contrast, the PriceWaterhouseCoopers study conducted in June was based on actual and current enrollment data from CMS. According to that study, of the 3.5 million who may hit the high deductible-portion (Stage 3), **very few will be there very long.** Most of them **either** will:

- pay only a few hundred dollars (**Group A**) of the high deductible-portion for a few months before the beginning of the next year – when they will return to their basic savings benefits (Stage 2); **or**

[14] PriceWaterhouseCoopers, "Significance of the Coverage Gap Under Medicare Part D," June, 2006.

- reach Stage 4 quickly due to very high drug costs (**Group B**), and begin to benefit from the catastrophic (95 percent) coverage.

Reality Versus Politics

In the last decade, the rising costs of newer and important prescription medications for seniors made the need for a Medicare drug benefit clear. There were many different legislative efforts over the last decade to accomplish this. These included Democratic proposals which would have provided benefits only to low-income seniors rather than all seniors,[15] and which would have limited benefits to only six years.[16] **Medicare Part D is for all seniors in Medicare, regardless of income, and it lasts for their lifetimes.**

Another plan proposed by President Bill Clinton – and embraced by many Democrats in the House and Senate in 2000, called for a gap in coverage (akin to the high deductible-portion in the Part D standard plan) and relied on private negotiation of drug prices instead of through the government.[17] Yet, these are the aspects of Part D which Democrats are attacking now that Republicans passed and implemented a successful benefit (for which many Democrats have admitted their elderly constituents should sign up).

They now say that if the federal government negotiated prescription drug prices directly with manufacturers, that would drop costs and eliminate the need for there to be a high split-deductible design. But the Congressional Budget Office (CBO) has denied the validity of this claim and even warned that government negotiation, or price-setting, could make some drugs even more expensive for seniors.[18]

Democrats also allege that the enrollees who spend enough to hit the high deductible-portion – the "doughnut hole," as they call it – will thereafter be paying monthly premiums without getting any benefits, year after year. That is not only unfair but also untrue. Those 15 percent of enrollees (see last section) who may reach Stage 3 this year:

1. are eligible for catastrophic coverage after paying their deductibles, and are insured if they fall ill and have drug costs over $5,100;

2. will have already received at least $1,500 of assistance in Stages 1 and 2;

3. will continue to benefit from the low, discounted prices that their plans have negotiated with manufacturers (Congress mandated that enrollees get these discounts at all times); and,

4. will be able to switch to a plan without deductibles in November – if they desire.

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[15] SA 4345, 107th Congress.
[16] S. 2625 introduced June 14, 2002.
[17] S. 2541, introduced May 10, 2000; H. 4770, introduced June 27, 2000.
[18] Former CBO director Douglas Holtz-Eakin in a 2005 Senate hearing and in separate 2004 letters to Senate Majority Leader Bill Frist and Sen. Ron Wyden.

5. CMS has a great deal of information to help those paying the high deductible-portion.

Because the opponents of Part D have closed their eyes to the benefits of the private competition in Medicare, they fail to appreciate how many plans are not based on the standard design on which they focus their ire. Part D is not government-dictated – it is not one-size-fits-all. It has many different options to benefit seniors with different situations and quite a few of those plans do not include the infamous "doughnut hole."

The Benefits to Seniors Are Undeniable

The best evidence for the program comes from the personal stories of the seniors themselves who experience the program daily. *Wall Street Journal Online* has been tracking three different actual encounters with Part D by seniors with different incomes and health statuses.[19] Here are some excerpts from each of the three stories:

David and Mary Schlotterback (Plainfield, IL):

October 2005

For Mr. Schlotterback, 73, and his wife Mary, 74, it's not a question of whether to enroll in the new Medicare drug benefit program but which drug plan to choose. The couple spends about $20,000 a year on prescription drugs to treat a range of ailments – his wife suffers from depression, high blood pressure, arthritis and acid reflux disease, while he takes medications for high cholesterol, high blood pressure, arthritis and sinus problems.

"Every few months I'm looking for something to sell to replenish our income flow," Mr. Schlotterback says. "Drugs are covered by savings and we're eating into our savings. We aren't having to sacrifice too much, but it's our biggest single expense."

August 2006

Mary Schlotterback is already out of the doughnut hole – the coverage gap when beneficiaries of Medicare drug plans have to pay for their own drugs. With the Medicare plan now picking up most of the tab for his wife's drug bills, Mr. Schlotterback says he's saving a lot of money.

"Coming out of the doughnut hole is wonderful," he says. "Now things cost either $5 or 5%, whichever is higher. The highest amount I've paid since she came out of the doughnut hole was $9.25 and that was for something that might have cost about $200. There is no doubt about it that for her this is a wonderful thing and for me too because I pay the bills."

Mrs. Schlotterback hit the doughnut hole in May and emerged in July after spending only five months in a plan because she didn't enroll until February, he says.

Mr. Schlotterback says he expects he will learn he's hit the doughnut hole on his next visit to the pharmacy but because he mainly buys generic drugs, he doesn't expect to emerge until October or November. ***"Net-net we'll save at least $5,000 this year and that's a conservative estimate," he says.***

[19] *Wall Street Journal Online* series "Medicare Drug Benefit Diary", October, 2005 – August, 2006.

Isabela Brown (Arlington, VA):
February 2006

Isabela Brown, is starting to see savings from the Medicare drug benefit, but she still wonders whether the program is a good deal for seniors.

Ms. Brown, who paid almost $150 a month for prescription medications before signing up for a Medicare drug plan, spent about $32 when she filled her two prescriptions this month. Her insurance company picked up $73 of the cost on Zocor, her cholesterol medicine, and almost $44 on Norvasc, her blood-pressure drug. "I'm saving money," she says. "But I just feel that we should've left everything alone."

August 2006

Isabela Brown doesn't anticipate a run-in with the Medicare drug benefit's so-called "doughnut hole," a coverage gap that has pinched some seniors' wallets. "I spend $100 a month approximately, so I don't think I'm going to fall into that at all," she says.

Overall, Ms. Brown says she's still sailing along with her Medicare drug plan. "I'm one of their best customers with my two or three prescriptions a month," she says. Ms. Brown says getting her medications has been a breeze. And since her cholesterol drug, Zocor, went generic, she has increased her savings by about $15 a month.

The *Journal's* third story was about a senior named Bill Marten in Madison, Wisconsin, who, in calculating his anticipated prescription drug expenditures, did not expect to realize significant savings under a Part D drug plan. Importantly, however, he elected to participate in Part D because he recognized the program's inherent insurance value. ***"It's so close to break-even one way or another, I might as well buy the plan for the insurance value," he said.***

This underscores a critical point. By participating in a Part D plan, seniors receive the benefit of catastrophic protection – whether they know in advance that they will need it (like the Schlotterbacks), whether they care most about the basic savings it provides (like Isabela Brown), or whether they doubt they will save much but want to make sure they are covered just in case (like Bill Marten). With multiple options such that there is at least something for everyone, it is little wonder that seniors are expressing overwhelming satisfaction about the program.

Conclusion

This is the very first year of a landmark program – the most significant change to Medicare since it began in the 1960s. While it has already proven successful, it can only improve from here as kinks are worked out and as seniors become more familiar with the program. CMS is preparing to provide even more sophisticated information on plan options during this fall's enrollment period, now that it has actual data about enrollment and usage. Those tools, as well as increased awareness by seniors, should maximize the chances of seniors picking the plans with the very best benefits packages for them.

Despite what opponents claim, not only does the so-called “doughnut hole” have very limited effects this year, it is even less likely to be a significant issue in future years as information and options improve, and as seniors become more savvy about how to pick the best plans for their individual situations – with or without a split-deductible design. Hitting the high deductible-portion (the “hole”) will become a calculated choice most of the time. And those who do not want to have one simply will choose a plan without one.

Awareness is one factor that individual lawmakers and even average Americans can influence. Spreading factual information about the options available to seniors and dispelling the myths will help improve the program for all.